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DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445181	A. BUILDING _____ B. WING _____	10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HILLS NURSING CENTER	2034 COCHRAN RD MARYVILLE, TN 37803

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F 161 SS=F	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident trust fund accounts, review of the facility's surety bond, and interview, the facility failed to ensure the amount of the surety bond was sufficient to cover the resident trust fund account for seventy-three of seventy-three residents with trust fund accounts. The findings included: Review of the Resident Fund Management Service (trust fund accounts) report revealed the following balances: on August 31, 2011=$80,011.79; on September 30, 2011=$80,593.17; and October 4, 2011=$82,111.16. Review of the facility's surety bond for trust fund accounts revealed the amount of the bond was $65,000.00. Interview on October 5, 2011, at 12:05 p.m., with the Administrator, in the Administrator's office, confirmed the surety bond was not sufficient.	F 161	***Preparation of and / or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because of federal and state requirements*** **F161: Surety Bond** 1) What corrective actions will be taken to correct this alleged deficient practice? a) The facility obtain a surety bond of $85,000 on 10/05/2011 to cover the resident trust accounts. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility have the potential to be affected. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) The facility Business Office Manger will audit the resident trust fund monthly for 3 months to ensure that the surety bond is large enough to cover the resident trust account and quarterly for 6 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250		

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 10/14/2011

leficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued arm participation.

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F 250	Continued From page 1 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Intakes: TN00028761 Intakes: TN00028761 Based on medical record review, facility policy review, and interview, the facility failed to provide medically-related social services for one discharged resident (#23) of twenty-eight residents reviewed. The findings included: Resident #23 was admitted to the facility on July 22, 2011, with diagnoses including Rehabilitation, Muscle Weakness, Difficulty Walking, End-Stage Renal Disease, Hypertension and Chronic Obstructive Pulmonary Disease. Medical record review of an Initial Discharge Planning form completed by Social Services, dated July 22, 2011, revealed, "...Anticipated Length of Stay: will d/c (discharge) to (family's) home August 11, 2011..." Medical record review of a Discharge Assessment Summary and Discharge Instructions dated August 8, 2011, revealed, "...Copy of Instructions Given To: Resident (with box beside of resident checked)...Resident's Signature/Person Receiving Instructions: (this section was blank with no signature)...Date:	F 250	a) The business office manager will report the audit results to the Performance Improvement Committee for 3 months. b) The Performance Improvement Committee; (Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Medical Records Director, Human Resources Supervisors, Activities Director, Rehabilitation Manager, Housekeeping Supervisor, Maintenance Director, Dietary Manger, Admission Coordinator, Social Services Director, Register Dietician, Business Office Manager, Pharmacy Consultant and Medical Director); will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revise and/or the audits reviewed, for three months or until 100% compliance is achieved. **F250: Provision of Medically Related Social Service** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #23 was discharged on 8/11/2011.	10/14/2011

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F 250	Continued From page 2 August 11, 2011...Licensed Nurse's Signature: (this section was blank with no signature)..." Medical record review of a Nurse's Note dated August 11, 2011, revealed, "...resident left facility without reviewing d/c instructions-did not receive copy of d/c instructions..." Medical record review of the Social Service Progress Notes revealed no documentation Social Services called the resident or the resident's family to review the discharge instructions and provide medically-related social services for the resident. Review of facility policy "Discharge/Transfer of the Resident" revealed, "...6. c. Have resident and/or representative/person responsible for care sign discharge summary and post discharge care form...d. Give copy of form to the resident and/or representative/person responsible for care..." Interview by telephone with Social Worker #1 on October 5, 2011, at 10:00 a.m., confirmed Social Worker #1 was aware the resident was discharged from the facility without review or copies of discharge instructions. Continued interview confirmed Social Worker #1 failed to call the resident or the resident's family to review the discharge instructions and provide medically-related social services for the resident. Interview with Social Worker #2 on October 5, 2011, at 2:15 p.m., in the Conference Room, confirmed Social Worker #2 was aware the resident was discharged from the facility without review or copies of discharge instructions. Continued interview confirmed Social Worker #2	F 250	2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents who are discharged from the facility has the potential to be effected. b) Clinical Compliance Nurses (RN), reviewed 100% discharge records for dates of 8/11/2011 – 9/30/2011 to ensure appropriate documentation for discharge planning by social services. The discharge records were also reviewed for family/resident and nurse signatures on the discharge instruction form. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? a) Regional Vice President has in-serviced the social services departments on the discharge planning process which includes: review of resident discharges in the daily PPS meeting , communicating with families final choice regarding Home Health Companies, Medical Equipment, Pharmacy Preference, Primary Care Physicians and transportation to home. The SS will also communicate with other departments the resident's discharge plans. This was completed on 9/30/2011 and 10/20/2011. b) Director of Nurses in-serviced the nursing staff on the discharge planning process on 10/07/2011. c) Social worker #1 is no longer employed at this facility.	

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F 250	Continued From page 3 failed to call the resident or the resident's family to review the discharge instructions and provide medically-related social services for the resident. Interview with the Administrator on October 5, 2011, at 2:25 p.m., in the Administrator's Office, confirmed the resident was discharged from the facility without review or copies of discharge instructions. Continued interview confirmed the facility failed to call the resident or the resident's family to review the discharge instructions and provide medically-related social services for the resident. C/O #28761	F 250	d) Medical Records Director will audit the discharge record to ensure the facility has provided education and discharge plans were completed. Audit completed will be reviewed by the Director of Nursing using the discharge record audit weekly times 4 weeks and monthly for 2 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) Medical Records will report the results of the education and discharge audit to the Performance Improvement Committee for 3 months. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process will be evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview the facility failed to provide an environment free of odors for one resident (#16) of twenty eight residents reviewed. The findings included: Resident #16 was admitted to the facility on April	F 252	**F252: Clean and Comfortable Home Like Environment** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident # 16 bathroom was stripped and wax on 10/14/2011. This action removed the smell from the room. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility have the potential to be affected.	11/4/2011

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F 252	Continued From page 4 22, 2011, with Hypertension, Anxiety, Muscle Weakness and Enlarged Prostate. Observation on initial tour on October 3, 2011, at 8:50 a.m., in resident #16's room and the bathroom, revealed a strong urine odor. Interview with Registered Nurse (RN) #5 on October 3, 2011, at 8:50 a.m., in the resident's room and the bathroom confirmed the foul odor. Observation on October 4, 2011, at 8:45 a.m., in the resident's room and the bathroom, revealed a strong urine odor. Observation on October 5, 2011, at 7:40 a.m., in the resident's room and the bathroom, revealed a strong urine odor. Observation and Interview with the Administrator on October 5, 2011, at 8:10 a.m., on the 100 hallway, confirmed a urine odor present in the resident's room and bathroom.	F 252	b) The housekeeping supervisor completed a 100% audit of residents' room and bathroom on 10/21/2011. During this audit any room that had a urine smell will be stripped and waxed by 11/04/2011. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Quality rounds are completed weekly by the Executive Director and the housekeeping supervisor to detect any odors in the facility. If odors are noted it will be addressed immediately. b) The housekeeping supervisor will make monthly check of resident room monthly for 3 months or until 100% compliance is achieved. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) The housekeeping supervisor will report the results of the audit to the Performance Improvement Committee for 3 months. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	11/4/2011
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a quarterly Minimum Data Set assessment for one (#2) of twenty-eight	F 276		

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F 276	Continued From page 5 residents reviewed. The findings included: Resident #2 was readmitted to the facility on July 26, 2011, with diagnoses of Urinary Tract Infection, Dementia, Pyuria, Anxiety and Stroke. Medical record review revealed a significant change of status Minimum Data Set (MDS) with an assessment reference date of June 14, 2011 (prior to readmission), was the most recent MDS assessment completed. Interview with Registered Nurse #6 on October 4, 2011, at 8:58 a.m., in the nursing office, confirmed a quarterly MDS assessment was due 92 days from the last MDS assessment. Continued interview confirmed no MDS assessment had been completed since June 2011.	F 276	**F276: Quarterly Assessment** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #2 had a significant change MDS, which was completed on 10/04/2011 by the MDS coordinator.. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility have the potential to be affected. b) The Resources Utilization Specialist completed 100% audit of the MDS schedules reconcile against the current resident census on 10/10/2011 to ensure the quarterly assessment were completed at least every 92 days. Audit reveals that no other quarterly assessments were missed.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) MDS coordinators were in-service on 10/18/2011 by the Director of Nurses on the process of scheduling MDS assessments using the MDS schedule printed from computer system. The MDS coordinator responsible for the long term care residents will also maintain a manual tickler file to reconcile with the MDS schedule printed from the computer system to ensure quarterly assessment are completed every 92 days.	

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F 278	Continued From page 6 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately assess falls on the quarterly assessment for one resident (#21) of twenty-eight residents reviewed. The findings included: Resident #21 was admitted to the facility January 21, 2011, with diagnoses including Alzheimer's Dementia, Diabetes Mellitus, Hypertension, and Congestive Heart Failure. Medical record review of the nurse's note dated June 9, 2011, at 8:15 p.m., revealed "...observed (the resident) lying in floor, bed was low, mat was in place, alarm had sounded..." Medical record review of the Minimum Data Set (MDS) dated August 9, 2011, Section J, revealed no falls had occurred since the last assessment, May 17, 2011.	F 278	b) Director of Nursing will complete a MDS audit printed from the computer to ensure quarterly assessment are completed every 92 days, monthly time 3 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) Director of Nurses will report the MDS audit to the Performance Improvement Committee for 3 months. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revise and/or the audits reviewed, for three months or until 100% compliance is achieved. **F278: Assessment Accuracy** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #21 had MDS attestation on the 8/09/2011 quarterly assessment to include fall, which occurred on 6/09/2011. This attestation was completed on 10/05/2011 by the MDS coordinator. 2) Identify residents that have the poteptial to be affected by the alleged deficient practice? a) Residents in the facility have the potential to be affected.	KH/10/31

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F 278	Continued From page 7 Interview with MDS Coordinator #1, on October 5, 2011, at 2:20 p.m., in the conference room, confirmed the resident's fall on June 9, 2011 was not included on the August 9, 2011 quarterly assessment.	F 278	b) The Resources Utilization Specialist completed 100% audit of the MDS and resident falls for the last 90days to ensure accuracy of the MDS coding related to falls on 10/21/2011. The audit revealed that two residents' falls were not captured on the MDS. The MDS coordinator on 10/21/2011 completed modifications of these two records. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Director of Nursing In-serviced the MDS coordinators on 10/20/2011 regarding the new process which includes the Director of Nursing will print a falls report monthly and provide a copy to the MDS coordinator to ensure the fall are recorded accurately. MDS coordinator will continue to review the medical records for the documentation for falls and continue to attend the events meeting where resident falls are reviewed. b) The Assistant Director of Nurses will audit 10% of the MDS completed for accurate coding for falls weekly times 4 then monthly times 2 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) Assistant Director of Nurses will report the results of the MDS audit for accurate coding of falls to the Performance Improvement Committee for 3 months.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to evaluate and revise the care plan for one resident (#2), and failed to invite two residents (#17 and #18) to a care plan meeting of twenty-eight residents reviewed.	F 280		

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F 280	Continued From page 8 The findings included: Resident #2 was admitted to the facility on July 26, 2011, with diagnoses of Urinary Tract Infection, Dementia, Pyuria, Anxiety and Stroke. Medical record review of a Progress Note dated September 12, 2011, revealed "...Resident in physical decline." Medical record review of the current Interdisciplinary Care Plan reviewed June 23, 2011, revealed the care plan had not been revised to reflect the resident's physical decline. Medical record review of the Physician's Order dated October 3, 2011, "...Consult Hospice..." Interview with Registered Nurse (RN) #6 on October 4, 2011, at 8:58 a.m. in the nursing office, confirmed the Interdisciplinary Care Plan had not been updated or revised to reflect the resident's current status. Resident #17 was admitted to the facility on April 5, 2009, with diagnoses of Chronic Obstructive Asthma, Shortness of Breath, Hypertension, and Congestive Heart Failure. Medical record review of the resident's Minimum Data Set (MDS) dated August 9, 2011, revealed the resident scored a 15 on the Brief Interview of Mental Status (BIMS) which indicated the resident was cognitively intact. Interview with the resident on October 4, 2011, at 11:40 a.m., in the resident's room, confirmed the	F 280	b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revise and/or the audits reviewed, for three months or until 100% compliance is achieved. **F280: Right to Participate Planning of Care** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #2 care plan was revised by the MDS coordinator on 10/13/2011 to reflect the resident physical decline. b) Resident #17 was invited by the MDS coordinator on 10/18/2011 and the resident attended with documentation on the care plan conference record. c) Resident #18 was invited by the MDS coordinator on 10/19/2011 and the resident attended with documentation on the care plan conference record. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility have the potential to be affected. b) Interdisciplinary Team (Activities Supervisor, Register Dietitian, Unit Manager, Social Services Director, Rehabilitation Manager and the MDS	11/10/2011

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F 280	Continued From page 9 resident had not been invited to care plan meetings. Further interview with the resident confirmed the resident had no knowledge of any care plan meetings, and would like to attend a care plan meeting. Resident # 18 was admitted to the facility on May 20, 2011, with diagnoses of Weakness, Osteoarthritis, Hypertension and Congestive Heart Failure. Medical record review of the MDS dated August 16, 2011, revealed the resident scored a 13 on the BIMS which indicated the resident was cognitively intact. Interview with the resident on October 4, 2011, at 11:37 a.m., in the resident's room, confirmed the resident had not been invited to care plan meetings. Further interview with the resident confirmed the resident had no knowledge of any care plan meetings, and would like to attend. Interview with Social Worker #3 on October 3, 2011, at 9:45 a.m., in the social worker's office, confirmed the residents (#17 and #18) had not been invited or notified of a care plan meeting and the residents had not attended a care plan meeting.	F 280	Coordinator); met to review current residents to identify resident with physical decline on 10/21/2011 to ensure care plan revision. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Interdisciplinary team was in-serviced by the Resources Utilization Specialist on 9/30/2011 regarding how to individualize the care plan on the resident current condition Care Plan Conference Record. b) The Director of Nurses in-serviced the MDS coordinator on 10/17/2011 related to the process of inviting families/residents to care plan meeting which included mailing of card to families and take the card to the residents rooms to ensure the residents are being invited to care plan meeting. c) MDS coordinators attend the morning clinical meeting where resident changes in condition are discussed. d) The Director of Nursing will audit the family/resident invitation to ensure the families/resident are being invited to the care plan meeting weekly for 4 weeks then monthly times 2 months. e) The Director of Nursing will audit the care plan for residents identify with a physical decline weekly time 4 weeks and monthly times 2 months.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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F 281	Continued From page 10 Based on medical record review and interview, the facility failed to respond timely to a physician's/nurse practitioner's order for medication changes for two (#17 and #18) of twenty-eight residents reviewed. The findings included: Resident #17 was admitted to the facility on April 5, 2009 with diagnoses including Shortness of Breath, Hypertension, and Congestive Heart Failure. Medical record review revealed a pharmacy recommendation, dated July 26, 2011, for the treating physician to implement a gradual dose reduction of Ambien 5 mg. (milligrams), prescribed for resident #17 to take nightly at bedtime. Continued medical record review revealed no documentation the recommendation was received or reviewed by the Nurse Practitioner (NP) until August 23, 2011. Further review revealed NP #2 concurred with the recommendation, and wrote an order (August 23, 2011) to discontinue the scheduled dose of Ambien 5 mg nightly and continue the medication on an as needed (PRN) basis only. Further review revealed the facility failed to implement the physicians order until September 19, 2011. Resident #18 was admitted to the facility on May 20, 2011, with diagnoses including Dementia, Chronic Back Pain, and Osteoarthritis. Medical record review of a pharmacy recommendation dated July 26, 2011, revealed a	F 281	4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) Director of Nurses will report the results of the care plan audit invitation to the Performance Improvement Committee for 3 months. b) The Director of Nursing will report the result of the care plan audit that identifies residents with a physical decline. c) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved. **F281: Professional Standards** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #17 pharmacy recommendation dated 8/26/2011 were sent to the physician for a response. Nurse Practitioner declined the pharmacy recommendation on 9/21/2011. b) Resident #18 had no further pharmacy recommendation as of 9/2011. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility with pharmacy recommendations have the potential be affected.	11/4/2011

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F 281	Continued From page 11 recommendation from the pharmacist to the treating physician/nurse practitioner, to increase the dosage of Namenda 5 mg, prescribed for resident #18 from once daily to twice daily (BID). Continued medical record review revealed the recommendation was reviewed by the Nurse Practitioner (NP) August 23, 2011. NP #2 concurred with the recommendation, and wrote an order to increase the daily dose of Namenda 5 mg to BID. Medical record review of the Medication Administration records for resident #18, dated August 2011 and September 2011, revealed the facility failed to implement the physician's order until September 5, 2011, resulting in 13 missed doses of Namenda 5 mg for resident #18. Interview with the ADON (Assistant Director of Nursing) on October 5, 2011, at 7:30 a.m., in the facility conference room, confirmed the delays in implementing the physician's orders for residents #17 and #18. Interview with the DON (Director of Nursing) on October 5, 2011, at 1:20 p.m., also confirmed the delay in implementing the physician's orders for residents #17 and #18.	F 281	b) 100 percent audit of the July 26-28, 2011 pharmacy recommendations were reviewed on 10/20/11 by the Medicare Coordinator to ensure that all pharmacy recommendations have been addressed. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Medicare Coordinator was in-serviced on 10/04/2011 by the Director of Nurses regarding the new process on pharmacy recommendation follow-up. This includes providing the pharmacy recommendation to the physician within a timely manner and Medicare Coordinator will track the status of the pharmacy recommendation physician responses two times per week until physician has responded and addressed recommendation. b) The Director of Nursing will review the audit of the pharmacy recommendation physician responses to ensure timely completion weekly for 4 weeks, then monthly for 2 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) The Director of Nursing will report the result of the pharmacy recommendation audit to the Performance Improvement Committee. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process	
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	F 284		

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F 284	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to provide education on the post-discharge plan of care for one resident (#23) of five residents reviewed. The findings included: Resident #23 was admitted to the facility on July 22, 2011, with diagnoses including Rehabilitation, Muscle Weakness, Difficulty Walking, End-Stage Renal Disease, Hypertension and Chronic Obstructive Pulmonary Disease. Medical record review of an Initial Discharge Planning form completed by Social Services, dated July 22, 2011, revealed, "...Anticipated Length of Stay: will d/c (discharge) to (family's) home August 11, 2011..." Medical record review of a Discharge Assessment Summary and Discharge Instructions dated August 8, 2011, revealed, "...Copy of Instructions Given To: Resident (with box beside of resident checked)...Resident's Signature/Person Receiving Instructions: (this section was blank with no signature)...Date: August 11, 2011...Licensed Nurse's Signature: (this section was blank with no signature)..." Medical record review of a Nurse's Note dated August 11, 2011, revealed, "...resident left facility without reviewing d/c instructions-did not receive copy of d/c instructions..." Medical record review of the Social Service	F 284	evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved. **F284: Post Discharge Plan** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #23 was discharged on 8/11/2011. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents who are discharged from the facility has the potential be affected. b) Clinical Compliance Nurses (RN), reviewed 100% discharge records for dates of 8/11/2011 – 9/30/2011 to ensure appropriate documentation for discharge planning by social services. The discharge records were also reviewed for family/resident and nurse signatures on the discharge instruction form.. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Regional Vice President in-serviced the social services departments on discharge planning process on 9/30/2011 and 10/20/2011. b) Director of Nurses in-serviced the nursing staff on the discharge planning process on 10/07/2011.	11/4/2011

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F 284	Continued From page 13 Progress Notes revealed no documentation Social Services called the resident or the resident's family to provide education on the post-discharge plan of care for the resident. Review of facility policy "Discharge/Transfer of the Resident" revealed, "...6. c. Have resident and/or representative/person responsible for care sign discharge summary and post discharge care form...d. Give copy of form to the resident and/or representative/person responsible for care..." Interview with the Director of Nursing (DON) on October 3, 2011, at 1:30 p.m., confirmed the DON was aware the resident was discharged from the facility without resident or family education on the post-discharge plan of care. Interview by telephone with Social Worker #1 on October 5, 2011, at 10:00 a.m., confirmed Social Worker #1 was aware the resident was discharged from the facility without resident or family education on the post-discharge plan of care. Interview with Social Worker #2 on October 5, 2011, at 2:15 p.m., in the Conference Room, confirmed Social Worker #2 was aware the resident was discharged from the facility without resident or family education on the post-discharge plan of care. Interview with the Administrator on October 5, 2011, at 2:25 p.m., in the Administrator's Office, confirmed the facility failed to provide education to the resident or family on the post-discharge plan of care.	F 284	c) Social worker #1 is no longer employed at this facility. d) Medical Records Director will audit discharged records to ensure education was provided and discharge plans were completed. Audit will be completed and reviewed by the Director of Nursing using the discharge record audit weekly time 4 weeks and monthly for 2 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) Medical Records will report the results of the education and discharge audit to the Performance Improvement Committee for 3 months. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	11/4/2011

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F 284	Continued From page 14 C/O #28761	F 284		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to implement an individualized bladder training program for one (#20) of twenty-eight residents reviewed. The findings included: Resident #20 was admitted to the facility on March 13, 2007, with diagnoses including Convulsions, Depressive Disorder, and Psychosis. Medical record review of the Minimum Data Set dated May 3, 2011, revealed the resident was frequently incontinent of bladder. Medical record review of the Minimum Data Set dated July 26,	F 315	**F315: Restore Bladder** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #20 had a bladder assessment completed on 10/05/2011 by licensed nurse and bladder pattern tracking was completed on 10/12/2011 and resident placed on a schedule toilet program. The resident was screened on 10/21/11 by therapy for the incontinence program. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility that are incontinent require bladder training from the facility has the potential be affected. b) Nurse Supervisors will complete 100% audit of occasionally incontinent resident bladder assessments on 10/28/2011. Resident will be placed on an individualized bladder training program as indicated. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Director of Nurses and nursing supervisor will in-service the licensed nursing staff on completion of the Bladder assessment and implementing an individualized bladder training program on 10/28/11.	

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F 315	Continued From page 15 2011, revealed the resident was always incontinent of urine. Medical record review of the Assessment for Bowel and Bladder Training dated May 9, 2011, revealed the resident was a candidate for toileting, timed or scheduled voiding. Continued review of the Assessment for Bowel and Bladder Training dated May 9, 2011, revealed, "...cont (continue) check (and) change..." Review of the facility policy, Guidelines to Assessment, revealed, "...Quarterly: An Assessment for Bowel and Bladder Training is completed if the resident is incontinent. If there has been a change from the last quarter to this quarter, and the score is 0-14, proceed to completing the Urinary Incontinence Assessment..." Observation on October 5, 2011, at 8:15 a.m., revealed the resident seated in a wheelchair with a self release belt. Interview on October 5, 2011, at 12:30 p.m., with the Director of Nursing (DON), in the DON's office, confirmed no bowel and bladder assessment for August had been completed and no individualized bladder training program had been established for the resident.	F 315	b) The Unit Managers will bring the completed Bladder assessment forms and will be reviewed in the Clinical meeting which includes the Director of Nursing, the Assistant Director of Nursing, Nursing Supervisors and Unit Managers, and an individualized bladder program implemented. c) The Director of Nursing and Assistant Director of Nursing will audit the Bladder Assessments for completion of an individualized bladder training program weekly for 4 weeks and monthly for 2 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) Director of Nursing and/or Assistant Director of Nursing will report the results of the bladder assessment and resident placed individualize bladder training program to the Performance Improvement Committee for 3 months. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	11/4/2011
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to apply restraint devices correctly for two (#10 and #3) of twenty-eight residents reviewed. The findings included: Resident #10 was admitted to the facility on June 23, 2011, with diagnoses including Dementia, Cerebrovascular Accident, and Adult Failure to Thrive. Medical record review of the Minimum Data Set dated September 20, 2011, revealed the resident had severely impaired cognitive skills, required extensive assistance with transfers and did not walk. Medical record review of a physician's order dated August 22, 2011, revealed the resident was to have a restraint belt applied when in the wheelchair due to a history of falls. Medical record review of a nursing note dated September 28, 2011, revealed "Called to room by CNA (Certified Nursing Assistant), resident had scooted off w/c (wheelchair) & was on knees in front of w/c-had gotten (restraint) belt loosened, was still in place was facing away from w/c. Denies pain, said was trying to get up. Placed back in w/c, belt tightened until smaller one obtained..."	F 323	**F323: Free of Accident** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #10 restraint device was reapplied correctly on 10/04/2011 by the restorative nursing assistant. The physician order date 10/04/2011 to discharge the posey belts and wheelchair, place resident in broda chair with thigh strips due to poor safety awareness. b) Resident #3 restraint device was reapplied correctly on 10/04/2011 by nursing staff. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility with physician orders for restraint device have the potential to be affected. b) Restorative Nurse Aide completed a 100% observation on 10/04/2011 with residents who have restraint device for proper application of the restraint belt. The observation reveals 100% complaint with the restraint application. c) Therapy staffs screen 100% of resident with posey belts to ensure that the device was appropriate.	

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F 323	Continued From page 17 Observation on October 3, 2011, at 10:45 a.m., revealed the resident lying on the bed, sleeping, with a fall mat on the floor, beside the bed. Interview on October 4, 2011, with the Director of Nursing (DON), at the nursing station, confirmed after completing the investigation of the fall on September 28, 2011, the restraint belt was not applied correctly and was too loose at the time of the fall. Resident #3 was admitted to the facility on October 23, 2010, with diagnoses including Hypertension, Dementia, and Failure to Thrive. Medical record review of a physician's order dated June 3, 2011, revealed, "...(lap) belt while (up) in w/c (wheelchair) due to lower ext. (extremity) weakness (and) poor safety awareness due to dementia..." Review of the application instructions for the lap belt revealed, "...lay the lap belt across the patient's thighs...Bring the ends of the connecting straps down at a 45-degree angle between the seat and the wheelchair sides...criss-cross the straps behind the chair and draw them around the opposite side kick spurs..." Observation and interview on October 4, 2011, at 8:55 a.m., with RN supervisor #3 revealed the resident in the hall seated in a wheelchair with a lap belt. Continued observation and interview revealed the right strap of the belt between the back of the wheelchair and the wheelchair seat, the left strap of the belt between the wheelchair side and wheelchair seat. Continued interview	F 323	3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) The Restorative Nursing Assistants, previously trained by the Restorative nurse on proper application of the Posey belt, completed competencies covering proper application of posey belt with the Certified Nursing Assistants beginning 10/4/2011. b) Restorative Nursing Assistants complete daily audit of proper application of posey belts daily for four weeks, weekly for 2 months. Director of Nurses reviews audit to ensure staff compliance with proper application. c) Restraint Reduction Committee which includes the Assistant Director of Nursing, Unit Managers, Social Services, Therapy, and Activities reviewed residents with posey belt restraints for possible reduction on 10/18/11 and will continue restraint reduction review weekly. Orders were obtained for residents that were appropriate for restraint reduction. d) The Director of Nursing will audit the Restorative Assistants daily review of proper application of posey belt weekly for 4 weeks and monthly for 2 months.	

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F 323	Continued From page 18 with RN Supervisor #5 confirmed the restraint was applied incorrectly.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to implement physician's orders timely, resulting in unnecessary medication doses for one (#4) of twenty-eight residents reviewed.	F 329	4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) Director of Nursing and/or Assistant Director of Nursing will report the results of the Posey belt application audit to the Performance Improvement Committee for 3 months. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revise and/or the audits reviewed, for three months or until 100% compliance is achieved. **F329: Drug Regimen** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #4 pharmacy recommendation dated 7/26/2011 was sent to the physician for a response. Nurse Practitioner accepted the pharmacy recommendation on 8/23/2011, order was implemented on 9/5/11. Resident #4 had no further pharmacy recommendation as of 9/2011. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility with pharmacy recommendations have the potential be effected.	11/4/2011

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F 329	Continued From page 19 Resident #4 was admitted to the facility on November 25, 2008, with diagnoses including Depressive Disorder, Chronic Obstructive Pulmonary Disease, and Generalized Muscle Weakness. Medical record review of a pharmacy recommendation dated July 26, 2011, revealed a recommendation by the pharmacy, to the treating physician/nurse practitioner to discontinue Mirtazipine 15 mg (milligrams), an anti-depressant prescribed for resident #4 to take nightly, at bedtime. Continued medical record review revealed no documentation the recommendation was reviewed by the Nurse Practitioner (NP) until August 23, 2011 when NP #2 concurred with the recommendation and wrote an order to discontinue the Mirtazipine August 23, 2011. Medical record review of the Medication Administration Records for August 2011 and September 2011 revealed the facility failed to discontinue the medication until September 5, 2011, resulting in 13 unnecessary doses of Mirtazipine 15 mg. Interview with the ADON (Assistant Director of Nursing) on October 5, 2011, at 7:30 a.m., in the facility conference room, confirmed the delay in implementing the physician's orders resulted in unnecessary doses of Mirtazipine administered to resident #4.	F 329	b) 100 percent audit of the July 26-28, 2011 pharmacy recommendations were reviewed on 10/20/11 by the Medicare Coordinator to ensure that all pharmacy recommendations have been addressed. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Medicare Coordinator was in-serviced on 10/04/2011 by the Director of Nurses regarding the new process on pharmacy recommendation follow-up. This includes providing the pharmacy recommendation to the physician within a timely manner and Medicare Coordinator will track the status of the pharmacy recommendation physician responses two times per week until physician has responded and addressed recommendation. The Medicare Coordinator will write the telephone order for any recommended changes approved by the physician when she receives the signed recommendation back from the physician to ensure timely implementation of the current order. b) The Director of Nursing will review the audit of the pharmacy recommendation physician responses and the telephone orders written to ensure timely completion weekly for 4 weeks, then monthly for 2 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) The Director of Nursing will report the result of the pharmacy recommendation	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

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F 425	Continued From page 20 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide pharmaceutical services in a timely manner for one resident (#17) of twenty eight residents reviewed. The findings included: Resident #17 was admitted to the facility on April 5, 2009, with diagnoses including Shortness of Breath, Hypertension, Chronic Obstructive Asthma, and Psychosis. Medical record review of the Medication Administration Record dated April 2011, revealed the resident did not receive "...Spiriva/Handihaler(bronchodilator) 18 mcg	F 425	audit and telephone orders written to the Performance Improvement Committee. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revise and/or the audits reviewed, for three months or until 100% compliance is achieved. **F425: Pharmaceutical Services** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #17 received Spiriva 4/29/2011 as ordered by the physician. b) Resident's Medication Administration Record was audited by the Director of Nursing 10/2001 for June, July, August, and September 2011 MARs and no other doses of the Spiriva were missed. c) Nurse received one on one re-education on process of contacting the pharmacy and supervisor to ensure that medication is obtained in a timely manner and that no dosage is missed on 5/3/2011. 2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility with physician orders for Spiriva have the potential to be affected. b) Nursing Supervisors began auditing the Medication Administration Records daily on 10/12/11 to ensure no missed doses of medication.	11/4/11

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F 425	Continued From page 21 (micrograms) 1 cap(capsule)..." on April 25, 26, 27, and 28, 2011, at 8 a.m. Medical record review of Nurses's Notes dated May 2, 2011, late entry, revealed "...Spiriva...held for 4 days with no MD (medical doctor) order to hold til new one arrived..." Interview with the Director of Nursing (DON) on October 3, 2011, at 9:12 a.m. in the Director of Nursing office, confirmed the resident did not receive the medication for four days and the facility failed to acquire the medication in a timely manner.	F 425	3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Staffing Development Coordinator inserviced licensed nursing staff on 5/5/11 on preventing medication errors. b) Director of Nursing inserviced the licensed nurses on 10/17/11 on Medication Administration which includes the process when medication is unavailable.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to respond timely to a pharmacy recommendation for five (#4, #17, #18, #9, and #20) of twenty-eight residents reviewed. The findings included:	F 428	c) Nursing Supervisors began auditing the Medication Administration Records daily on 10/12/11 to ensure no missed doses of medication. d) The Director of Nursing will review the audit of Medication Administration Record for completion weekly for 4 weeks, then monthly for 2 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) The Director of Nursing will report the result of the Medication Administration Audit to the Performance Improvement Committee. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	11/4/2011

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F 428	Continued From page 22 Resident #4 was admitted to the facility on November 25, 2008, with diagnoses including Depressive Disorder, Chronic Obstructive Pulmonary Disease, and Generalized Muscle Weakness. Medical record review of a pharmacy recommendation dated July 26, 2011, revealed a recommendation by the pharmacy to the treating physician/nurse practitioner to discontinue Mirtazipine 15 mg (milligrams), an anti-depressant prescribed for resident #4 to take nightly, at bedtime. Continued medical record review revealed no documentation the recommendation was received or reviewed by the Nurse Practitioner (NP) until August 23, 2011 when NP #2 concurred with the recommendation and wrote an order to discontinue the Mirtazipine, resulting in a 28 day delay in discontinuing the medication. Resident #17 was admitted to the facility on April 5, 2009 with diagnoses including Shortness of Breath, Hypertension, and Congestive Heart Failure. Medical record review revealed a pharmacy recommendation, dated July 26, 2011, for the treating physician to implement a gradual dose reduction of Ambien 5 mg (milligrams), prescribed for resident #17 to take nightly at bedtime. Continued medical record review revealed no documentation the recommendation was received or reviewed by the Nurse Practitioner (NP) until August 23, 2011 when NP #2	F 428	**F428: Drug Regimen Review Report Irregular** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #4 pharmacy recommendation dated 7/26/2011 was sent to the physician for a response. Nurse Practitioner accepted the pharmacy recommendation on 8/23/2011, order was implemented on 9/5/11. Resident #4 had no further pharmacy recommendation as of 9/2011. b) Resident #17 pharmacy recommendation dated 8/26/2011 was sent to the physician for a response. Nurse Practitioner declined the pharmacy recommendation on 9/21/2011. c) Resident #18 had no further pharmacy recommendation as of 9/2011. d) Resident #9 pharmacy recommendation dated 6/23/2011 was sent to the physician for response. The nurse practitioner signed on 7/27/2011. Pharmacy recommendation dated 8/26/2011 was written by nurse practitioner on 9/21/11. e) Resident #20 pharmacy recommendation dated 7/27/2011 was sent to the physician for response. The nurse practitioner signed the recommendation on 8/23/2011, medication was started on 8/25/2011.	

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F 428	Continued From page 23 concurred with the recommendation and wrote an order to discontinue the scheduled dose of Ambien 5 mg nightly and continue the medication on an as needed (PRN) basis only. This resulted in a 28 day delay in initation of the medication reduction. Resident #18 was admitted to the facility on May 20, 2011, with diagnoses including Dementia, Chronic Back Pain, and Osteoarthritis. Medical record review of a pharmacy recommendation dated July 26, 2011, revealed a recommendation by the pharmacist, to the treating physician/nurse practitioner to increase the dosage of Namenda 5mg, prescribed for resident #18 to take once daily. The pharmacy recommended that the dose be increased to Namenda 5mg twice daily (BID). Continued medical record review revealed no documentation the recommendation was received or reviewed by the Nurse Practitioner (NP) until August 23, 2011 when NP #2 concurred with the recommendation and wrote an order to increase the daily dose of Namenda 5 mg to BID. This resulted in a 28 delay in initiating the medication change. Interview with the ADON (Assistant Director of Nursing) on October 5, 2011, at 7:30 a.m., in the facility conference room, confirmed the delays in processing pharmacy recommendations and/or medication changes. Interview with the DON (Director of Nursing) on October 5, 2011, at 1:20 p.m., also confirmed the delay in processing pharmacy recommendations	F 428	2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility with pharmacy recommendations have the potential be effected. b) 100 percent audit of the July 26-28, 2011 and August 26-29, 2011 pharmacy recommendations were reviewed on 10/20/11 by the Medicare Coordinator to ensure that all pharmacy recommendations have been addressed. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Medicare Coordinator was in-serviced on 10/04/2011 by the Director of Nurses regarding the new process on pharmacy recommendation follow-up. This includes providing the pharmacy recommendation to the physician within a timely manner and Medicare Coordinator will track the status of the pharmacy recommendation physician responses two times per week until physician has responded and addressed recommendation. b) The Director of Nursing will review the audit of the pharmacy recommendation physician responses to ensure timely completion weekly for 4 weeks, then monthly for 2 months.	

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F 428	Continued From page 24 and/or medication changes. Resident #9 was admitted to the facility on October 1, 2010, with diagnoses including Dementia, Hypertension, Hypothyroidism, and Congestive Heart Failure. Medical record review of a pharmacy consultant report dated June 23, 2011, revealed "(resident #9) has a diagnosis of Alzheimer's disease/dementia, takes an atypical antipsychotic medication, Seroquel, and has documentation in the medical record of having experienced a TIA or stroke. Recommendation: Please evaluate whether the benefits of continuing Seroquel outweigh the risks, including cerbrovascular adverse events, in this individual with a history of stroke or TIA, compared to the benefits vs. risks of NO antipsychotic treatment. Rationale for Recommendation-An evaluation of pooled analyses for some atypical antipsychotic medications suggests a link between their use and cerebrovascular events in individuals with dementia-related psychosis. As such, the FDA had required that the prescribing information for all aypical antipsychotic medications include a warning which identified the potential increased risk for cerebrovascular adverse events..." Continued review of the pharmacy consultant report dated June 23, 2011, revealed "...Physician's Response: I have re-evaluated this therapy and wish to implement the following changes: (decrease Seroquel @ (at) HS (hour of sleep)-25 mg (milligrams)..." Continued review of the pharmacy consultant report dated June 23,	F 428	**4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** **a) The Director of Nursing will report the result of the pharmacy recommendation audit to the Performance Improvement Committee.** **b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revise and/or the audits reviewed, for three months or until 100% compliance is achieved.**	11/4/2011

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F 428	Continued From page 25 2011, revealed NP #2 signed the report as reviewed on July 27, 2011. Interview on October 5, 2011, at 9:00 a.m., with the Director of Nursing, in the conference room, confirmed the delay in notifying the Nurse Practitioner or Physician of the pharmacy recommendation from June 23, 2011, until July 27, 2011, (34 days). Resident #20 was admitted to the facility on March 13, 2007, with diagnoses including Convulsions, Depressive Disorder, and Psychosis. Medical record review of a Pharmacy Consultant Report dated July 27, 2011, revealed, "I have re-evaluated this therapy and wish to implement the following changes:...DC (Discontinue) Risperdal (and) observe closely for (increased) psychosis...(signed by the psychiatric nurse practitioner on August 23, 2011)" Medical record review of a physician's order dated August 25, 2011, revealed, "...DC Risperdal..." Interview on October 5, 2011, at 9:30 a.m. with the Director of Nursing, in the conference room, confirmed a delay in implementing the pharmacy recommendation.	F 428	**F 441: Infection Control** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #2 care giver, CNA #1 received in-service education on proper hand hygiene on 10/07/2011 by the Staff Development Coordinator, observed for proper hand hygiene according to facility policy by the Staff Development Coordinator 10/21/2011. b) Resident #28 care giver, hydration aide (CNA) #2 received in-service education on proper hand hygiene on 10/07/2011 by the Staff Development Coordinator, observe for proper hand hygiene according to facility policy by the Staff Development Coordinator on 10/17/2011.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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F 441	Continued From page 26 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and interview, the facility failed to perform proper hand hygiene for two residents (#2, and #28) of	F 441	2) Identify residents that have the potential to be affected by the alleged deficient practice? a) Residents in the facility have the potential be affected. b) The nursing staff received in-service education on proper hand hygiene on 10/07/2011 according to facility policy by the Staff Development Coordinator. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a) Hand hygiene monitoring /observation will be conducted by the Staff Development Coordinator 3 times a week for 4 weeks then monthly for 2 months. Director of Nursing will review the hand hygiene monitoring tool weekly for 4 weeks then monthly time 2 months. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) The Director of Nursing will report the result of the hand hygiene monitoring tool to the Performance Improvement Committee for 3 months. b) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	11/1/2011

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F 441	Continued From page 27 twenty-eight residents reviewed. The findings included: Observation on October 3, 2011, at 11:40 a.m., on the 100 hallway, revealed Certified Nurse Aide (CNA) #1 in resident #2's room adjusting the covers, then exited the room, repositioned a resident seated in a wheelchair in the hall and failed to wash the hands between residents. Interview with CNA #1 on October 3, 2011, at 11:42 a.m., on the 100 hallway, confirmed the CNA had not washed the hands between the residents. Observation on October 3, 2011, at 4:17 p.m., on the 100 hallway, revealed CNA #2 offering drinks to residents from the hydration cart; CNA #2 entered resident #28's room, adjusted items on bedside table, touched the resident on the shoulder and exited the room. Continued observation revealed CNA #2 then pushed a resident in a wheelchair in the hallway, reentered resident #28's room and exited the room. Continued observation revealed CNA #2 retrieved a milkshake from the hydration cart, entered resident #2's room, assisted the resident to drink the milkshake, exited the room, and failed to the wash hands between the residents. Interview with CNA #2 on October 3, 2011, at 4:19 p.m., on the 100 hallway, confirmed the CNA had not washed the hands between the residents. Review of the facility policy dated May 5, 2004, Hand Hygiene, revealed "...Handwashing...when hands are visibly dirty or contaminated..."	F 441		

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F 441	Continued From page 28 Interview with Director of Nursing (DON) on October 4, 2011, at 9:12 a.m., in the DON office, confirmed CNA #1 and CNA #2 did not follow the facility policy for hand hygiene and infection control.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record was complete for one (#2) and failed to ensure the medical record was accurate for one (#23) of twenty-eight residents reviewed. The findings included: Resident #2 was admitted to the facility on July 26, 2011, with diagnoses of Urinary Tract Infection, Dementia, Pyuria, Anxiety and Stroke.	F 514	**F 514: Records Complete/Accurate** 1) What corrective actions will be taken to correct this alleged deficient practice? a) Resident #2 medication administration record for August, September and October 2011was reviewed by the Regional Director of Clinical Services on 10/21/2011all scheduled medication were documented as administered. b) Resident #23 who was cared for by the Nurse Practitioner #1supervising physician was notified by a letter-dated 10/10/2011 that the NP no longer has practice privileges in this facility. 2) Identify residents that have the potential to be affected by the alleged deficient practice? **Resident #2** a) Residents in the facility with physician orders for Metoprolol have the potential be affected. b) The nursing supervisors began auditing Medication Administration Records on 10/12/2011 to ensure there are no missing doses. **Resident #23** c) The Nurse Practitioner #1supervising physician was notified by a letter-dated 10/10/2011 that the NP no longer has practice privileges in this facility to ensure no other residents have the potential to be effective.	

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F 514	Continued From page 29 Medical record review of the Physician Orders dated July 2011, revealed a physician's order for Metoprolol Tartrate 25 mg (milligram) tablet take ½ tab by mouth twice daily. Medical record review of the Medication Administration Record (MAR) dated July 2011, revealed "...Metoprolol Tartrate 25mg take ½ tab by mouth twice daily (DX: CVA)...", and seventeen out of twenty four doses of the scheduled medication were not documented as administered. Interview with the Director of Nursing (DON) on October 4, 2011, at 9:15 a.m., in the DON's office, confirmed there was no documentation of the scheduled medication being administered. Resident #23 was admitted to the facility on July 22, 2011, with diagnoses including Rehabilitation, Muscle Weakness, Difficulty Walking, End-Stage Renal Disease, Hypertension and Chronic Obstructive Pulmonary Disease. Medical record review of a Discharge Assessment Summary and Discharge Instructions dated August 8, 2011 (dated at the top of page one of two pages) revealed Nurse Practitioner (NP) #1's signature at the bottom of page two and dated August 8, 2011. Medical record review of a Nurse's Note dated August 11, 2011, revealed the resident left (discharged) the facility on August 11, 2011. Interview with NP #1 on October 4, 2011, at 9:00 a.m., in the Conference Room, confirmed the signature and date at the bottom of page two was	F 514	3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? **Resident #2** a) Director of Nursing inserviced the licensed nurses on 10/17/11 on Medication Administration which included the process when medication is unavailable. a) Nursing Supervisors began auditing the Medication Administration Records daily on 10/12/11 to ensure there were no missed doses of medication. d) The Director of Nursing will review the audit of the Medication Administration Record for completion weekly for 4 weeks, then monthly for 2 months. **Resident # 23** d) The Executive Director, Director of Nursing, Regional Vice-President and the Regional Director of Clinical Services conducted a meeting with the Medical Director who was also NP #1 supervising physician, regarding back dating of medical records, which includes the discharge summary is as being considered falsification and is not an acceptable standard of practice on 10/13/2011. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? a) The Director of Nursing will report the result of the Medication Administration Record audit to the Performance Improvement Committee for 3 months.	

DEPARTMENT OF HEALTH AND HUMA' 'ERVICES
CENTERS FOR MEDICARE & MEDICAIL ERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445181	A. BUILDING _____ B. WING _____	10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HILLS NURSING CENTER	2034 COCHRAN RD MARYVILLE, TN 37803

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F 514	Continued From page 30 back-dated by NP #1 and stated, "I signed and dated this after the resident discharged on August 11, 2011; I always back-date them to match the date on the top of page one." Interview with the Medical Director on October 4, 2011, at 11:10 a.m., in the Conference Room, confirmed the bottom of page two on the Discharge Assessment Summary and Discharge Instructions is to be dated on the actual date the form is signed. Interview with the Administrator on October 4, 2011, at 5:50 p.m., in the Conference Room, confirmed the bottom of page two on the Discharge Assessment Summary and Discharge Instructions is to be dated on the actual date the form is signed and stated, "Back-dating is falsification and is not an acceptable standard of practice". Continued interview confirmed the facility failed to maintain an accurate medical record for the resident.	F 514	b) The Executive Director will report to the Performance Improvement Committee on 10/25/2011 that NP#1 no longer has practice privileges at this facility. c) The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	11/4/2011